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ABSTRACT

This paper briefly describes the Division of Behavioral and Developmental Pediatrics, which is the child development and mental health clinical, research, and training center for the Department of Pediatrics at Evanston Hospital and Northwestern University Medical Center in Illinois. Responsibilities of the child psychiatrists within this division are explained and the tentative nature of the relationship between the Departments of Psychiatry and Pediatrics is noted. It is stressed that theoretical and economic obstacles must be overcome before the two disciplines can collaborate in the best interests of children and families. The role of the pediatrician is discussed and the quality of the physician-family relationship is considered. Since both child psychiatry and pediatrics direct their primary effort at supporting the fullest well-being of children, it is concluded that pediatric training should correct its current academic deviation back toward a course of comprehensive health delivery; and that both child psychiatry and pediatrics should work to collaboratively enrich each other's diagnostic and therapeutic insights. (NB)

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Child Psychiatry in Pediatrics: Existential Economics

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The Division of Behavioral and Developmental Pediatrics is the child development and mental health clinical, research and training center for the Department of Pediatrics at the hospital and the medical school. The Division employs 20 professional staff members, including two child psychiatrists at 20 hours and four hours respectively. The child psychiatrists have joint appointments in Pediatrics and Psychiatry. Among the pediatricians, however, only the Division chief has similar joint appointments, though his is only at the medical school faculty level, not the hospital staff level.

The child psychiatrists within this division of Pediatrics perform clinical consultation to several programs: a) our Center for Recovery from Pregnancy Loss and Childhood Death - a support service network for children, parents, schools and hospital staff; b) the Evaluation Center for Learning - a diagnosis and treatment unit serving children older than four years who have learning or behavior problems; and c)the Infant Care Program - a prevention and early intervention program of hospital-based perinatal visitation, newborn behavioral demonstration, child rearing information and parent support.

Teaching responsibilities include a seminar on pediatric evaluation and referral of common childhood emotional disturbances as well as a field seminar introducing pediatricians to psychiatric treatment facilities in the community.

Child Psychiatry plays no direct role in the intensive care nursery or the infant and early childhood development program - our infant-parent early diagnosis and intervention program. Non-physician mental health professionals with special training in infancy function integrally within these service teams. None of the psychiatric collaboration emanates or is funded from the Department of Psychiatry.

To date then, the relationship between the Departments of Psychiatry and Pediatrics remains tentative, perhaps even tangential, although deeply shared philosophical commitments exist between the Behavioral Pediatrics Division Chief and the child psychiatrists. Theoretical as well as economic road blocks must be hurdled before the two disciplines can collaborate in the best interests of children and families.

Due largely to inadequate information during training, pediatricians enjoy or suffer from little or no theoretical basis from which to understand children's behavior. Direct observation is their one handle into the roots and needs of various symptoms and conditions. While this theoretical naivete often misleads pediatric practitioners into conceptually reducing the influence of a child's environment, it also affords the pediatrician the freedom to utilize a wide net of supports for each child. At best, pediatricians bear an orientation toward prevention and an early and sustained identification of strengths as well as stresses or deficits within an infant and a family. Good pediatricians can take advantage of their atheoretical perspective to appreciate multiple potential inflences upon a

child's health and self-concept. Their organismic approach to diagnosis can help them recognize each infant's unique contribution, through physiological and behavioral functioning, to his or her own development within a family. At worst, their organic isolation during training leaves pediatricians with a pathological eye myopically focused on discovering symptoms and treating them as processes.

The pediatrician's relationship with an infant and family can routinely begin before birth, during the relatively accessible emotional states and stages of pregnancy. Such timing helps to base the therapeutic role in support of healthy processes as well as coping with crises that may result from stress or illness. Perhaps, too, since the pediatrician is thought to be concerned for a person's general well-being, the public does not identify him or her as a mental health professional. The safety of this illusion may present the pediatrician with a subtle opportunity to raise mental health issues within the comfort of a known all-be-it partially masked professional expectation.

Exciting research possibilities likewise occur in association with the early, regular, routine and critical pediatric care of infants and families. Convenient opportunities exist for conducting short-term and long-term longitudinal study of relational phenomena. Moreover, parents who have tested and trusted their pediatrician's support become loyal participants in research based in or referred from the primary care provider's office.

The financial drive for survival can sour even the most cooperative interdepartmental inclinations. Governmental and other third party support is dwindling for programs which address the full range of biopsychosocial health. Usually as well, a limited pool exists of potential referral sources and families within a community. Mental health workers with similar expertise and availability are challenged to peacefully divide territories for assessment and treatment. This tension seems to heighten when deliberations convene as to the care of the many cases of "at risk" infants who are not clearly disordered upon initial presentation.

Child Psychiatry has an historical home within the broad field of Psychiatry. With special regard for infant development, however, a contemporary opportunity and invitation to operate from a base in Pediatrics arises from the renewed momentum for comprehensive caring within the latter discipline. Child Psychiatry and, increasingly, Pediatrics direct their primary effort at supporting the fullest well-being of children. If Pediatrics hopes to fulfill its caregiving potential, pediatric training must first drastically correct its present academic deviation back toward a course of comprehensive health delivery. Whether the current trend resolves through separate or consolidated departments, this much seems advised - both fields must collaboratively enrich one another's diagnostic and therapeutic insights. If not, we may each survive the modern

economic threat to existence only to find ourselves regressed into a clinical science too conceptually poor and inexperienced to serve our advanced goals.